

Valley Vision Associates

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PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Patient Name: _____	Date: _____
Primary Care Physician: _____	Pharmacy: _____
Do you wear Glasses? YES NO	Do you wear Contact Lenses? YES NO

Medical History (Check all that apply or circle none): **NONE**

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Strabismus (crossed eyes) |
| <input type="checkbox"/> Diabetes: Type _____ | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Cataract | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Eye Surgery: _____ |

Medications:
<input type="checkbox"/> None
Med List Req: _____ Date: _____
<small>Tech Initials</small>

Medication Allergies:
<input type="checkbox"/> No Known Drug Allergies

Previous Hospitalization or Surgery: _____

				For Doctors & Techs	
Review of Systems: <i>Do you currently have any of the following problems:</i>	Yes	No	If YES, please explain	Initials & Date	Initials & Date
Eyes (e.g., pain, tearing, redness, itching, sudden loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Constitutional/Symptom (e.g., fever, weight loss/gain, fatigue)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
ENT/Mouth problems (e.g., hearing loss, sinus problems, cough)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cardiovascular (e.g., chest pain, irregular heart beat, pacemaker)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Respiratory problems (e.g., shortness of breath, wheezing)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hematologic/Lymphatic (e.g., bleeding, anemia)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Allergies (e.g., hay fever, hives)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Gastrointestinal problems (e.g., abdominal pain, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Urinary problems (e.g., pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Skin problems (e.g., rashes, excessive dryness, rosacea)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Musculoskeletal problems (e.g., muscle aches, joint pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Neurologic problems (e.g., numbness, weakness, headaches)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Endocrine problems (e.g., diabetes, thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Psychiatric problems (e.g., depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Alerts: <i>Do you have or are you using any of the following:</i>					
MRSA	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Flomax medication	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Allergy to adhesive	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Allergy to lidocaine	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Allergy to iodine	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Premedication prior to procedures	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Family History:

- | | | |
|---|---|---|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Crossed/Lazy Eye | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Cataract | <input type="checkbox"/> Macular Degeneration |

Social History:

Do you use....? Tobacco Yes No Alcohol Occasionally Rarely Never

Payment and Account Information:

**If you have both types of insurance (Vision and Medical) plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.

Please initial:

_____ I certify that I (or my dependent) have insurance and/or Medicare coverage, and assign direct payment to Valley Vision Associates for services and material benefits. I authorize the use of this signature on all insurance submissions.

_____ I understand that I am financially responsible for all co-pays, deductibles, materials, and services not covered by my insurance and/or Medicare. I authorize Valley Vision Associates to release any information necessary to secure payment of benefits.

_____ I understand that I am financially responsible for all materials and services in the event no insurance is provided.

_____ I have read and understand my HIPAA Rights and Responsibilities (we have a copy available at the Front Desk if needed)

_____ For patients with Medicare coverage- I understand that Medicare does not cover the refraction and that I am responsible for the \$44 refraction fee; the test in which the prescription for glasses is written.

_____ I request that Valley Vision Associates, upon request, release all information related to my health care and general well-being, to the people listed below other than myself. You have my permission to talk to and release all medical records and information related to my health care to the person(s) listed below. This request is to be in effect until I submit a written request for a change.

Name	Relationship	Phone Number

Signature

Date

Print Name